

Syracuse University

SURFACE

Center for Policy Research

Maxwell School of Citizenship and Public
Affairs

1996

Health Care: Public Good or Private Enterprise?

David M. Lawrence

Kaiser Foundation Health Plan

Follow this and additional works at: <https://surface.syr.edu/cpr>



Part of the [Health Policy Commons](#)

Recommended Citation

Lawrence, David M., "Health Care: Public Good or Private Enterprise?" (1996). *Center for Policy Research*. 37.

<https://surface.syr.edu/cpr/37>

This Working Paper is brought to you for free and open access by the Maxwell School of Citizenship and Public Affairs at SURFACE. It has been accepted for inclusion in Center for Policy Research by an authorized administrator of SURFACE. For more information, please contact surface@syr.edu.

SYRACUSE UNIVERSITY
MAXWELL SCHOOL OF CITIZENSHIP AND PUBLIC AFFAIRS | CENTER FOR POLICY RESEARCH

Policy Brief

Health Care: Public Good or Private Enterprise?

David M. Lawrence

No. 6/1996

David M. Lawrence, M.D., is Chairman and CEO of the Kaiser Foundation Health Plan, the nation's largest, and one of its oldest health maintenance organizations, which celebrated its 50th anniversary in 1995.

The Policy Brief series is a collection of essays on current public policy issues in aging, health, income security, metropolitan studies and related research done by or on behalf of the Center for Policy Research at the Maxwell School of Citizenship and Public Affairs.

Single copies of this publication may be obtained at no cost from the Center for Policy Research, Maxwell School, 426 Eggers Hall, Syracuse, NY 13244-1090.

© 1996, Syracuse University

Health Care: Public Good or Private Enterprise?

David M. Lawrence

Introduction

I start with the premise that the success of our efforts in health care is best measured by our ability to impact the health status of our citizens in the most affordable way possible. This brief provides an overview of the history of organized health care systems, then discusses several of the conundrums that are posed by knowledge of that history.

But before I do that, I'd like to set the stage by summarizing the kinds of things that are going on in health care now.

The Health Care Market of the 1990s

The state of health care in the 1990s can best be summarized by a series of projections produced by Deloitte & Touche a few years ago.

According to those projections, half the hospital beds in the United States will be closed by the end of the decade.

In addition, based on the experienced of well-organized, well-integrated health care systems, there are probably 100,000 to 125,000 excess physicians in the United States. Many of those physicians are trained in the wrong specialties, creating not only an excess of gross supply but also an excess supply of subspecialists, and a real imbalance between the specialty and primary care activities in medical care.

Beyond the excess capacity, there is explosive growth in the for-profit sector in health care. The best example of this is Columbia HCA, which started as a hospital care organization, but is now moving into integrated care. Five or six years ago, Columbia was just a small bit player. Now it has become the largest health care organization in the country, with approximately \$17 billion in annual revenues, owning and running 350 to 400 hospitals across the United States.

Alternatively, look at the rapid growth of United Health Care, which I would describe as a managed contracting or managed discounting organization, rather than a managed care organization. But if one looks at their price-earnings multiples or their recent acquisition of the large insurance capability that jumped their membership from about 2 to 12 million people whose lives they cover, one begins to get a sense of the degree to which health plans, insurance, and health care organization and delivery are being influenced by the explosion in for-profit care.

If one looks at places like Portland, Oregon, one sees the impact of this change in the organization of the health care delivery system. In 1994, we studied what was happening to that marketplace, because we have a long-standing plan there. About one in five people in Portland receive their care through our system. For years and years, our competitor was Blue Cross/Blue Shield of Oregon.

The market began to change in the late 1980s. We projected that within 18 months Portland would shift from 80 percent fee-for-service and 20 percent with Kaiser Permanente to a situation in which about 85 to 90 percent of the population of Portland would be cared for in one of three plans, all of them managed care plans. It converted almost overnight! And it was only one example.

Even as we considered public policy-driven health care reform at the national and state levels, there was a revolution occurring underneath the surface, driven by market forces, which has radically transformed the health care industry. What's interesting about this transformation is that it is just the beginning; the real fun is about to occur. What's been going on in the health sector over the last four to five years has been a shift from an industry that was highly fragmented to one that now has in place the elements for an economic marketplace to begin to play itself out.

Here are some of the elements of that change:

- ▶ ***Purchasing Coalitions.*** Until about 1988 or 1989, most purchasers—by which I mean large employers—simply paid the bill. But with intense international competition and the cost of health care continuing to skyrocket, it simply became too big a cost to ignore. Purchasers began to band together into purchasing coalitions to try very aggressive alternative ways of buying health care. For example, Xerox and GTE began putting enormous pressure on the health care system. That had never happened before.
- ▶ ***Health Care Surplus.*** There was a tremendous discontinuity in the health care marketplace, in that the supply was far in excess of demand. That provides an opportunity for people who are willing to take advantage of it to come in and redress the supply-demand imbalance. While other opportunities for capital investment had somewhat dwindled, the excitement of the health care stocks attracted a great deal of Wall Street money, following entrepreneurs like Rick Scott and others who entered health care for the purpose of taking advantage of the imbalance in supply and demand.
- ▶ ***Health Care Provider Coalitions.*** It's been fascinating to watch the emergence in a relatively short period of time of fairly powerful medical group-hospital combinations, in part to bring together what we've learned about managed care, and in part to protect themselves from the leverage that insurers and health plans have been able to gain by aggregating populations that they cover. In other words, if I as a health plan have control over 1 or 2 million lives, I can deliver those patients to a group of physicians and a hospital and gain tremendous leverage in the contracting. Obviously, that is a natural process when there is too much supply.

What has happened is that many physician groups have begun to come together with hospitals, or independently, to create their own counterbalance to that leverage on the part of the purchasers, or on the part of the financiers of care.

We have all of these elements in play. There are a number of very troubling issues that this particular period in health care in the United States poses for us.

Impetus for Organized Health Care in the United States

Emily Friedman, who is a writer, ethicist, and medical historian, gave a lecture on the history of organized health care systems at the American Hospital Association's annual convention.¹ She was asked by the Minnesota Hospital Association (now the Minnesota Hospital and Health Care Partnership) to do a history of health care in Minnesota, and it's on this basis that she developed these observations. This was in addition to some work she did in 1994 on the early history of capitation and health systems.

In her Minnesota work, she started to ask, "What about the organized systems? What about the Mayos, the Health Partners, and other organizations like that? How did they start?" Interestingly, she found that these systems originated in three distinct streams or sets of activities. The first, especially in the north-central and northwestern parts of the United States, was an outgrowth, she believes, of the cooperative movement that Swedish, Norwegian, and Finnish immigrants brought to the United States. Its roots were in the collectivism, or the cooperative movement, of Northern Europe. When one looks at the development of Group Health Cooperative of Puget Sound just before World War II or at the antecedents to Health Partners in Minnesota, one sees how that the cooperative movement has played through the organization of these kinds of systems.

The second major force that drove the development of these systems was employers. We are the beneficiary, for example, of Henry Kaiser, who needed to provide health care to his workers building Grand Coulee Dam, before World War II, and later needed to provide health care to his workers during World War II, when he was building ships. It was a leader, an entrepreneur like Henry Kaiser, who really gave the impetus for the development of our kind of organization.

Third, there was an impetus that came from providers themselves, as they sought a better alternative to care than the one that they were experiencing in traditional fee-for-service medicine.

¹Friedman, Emily. "The Past as Future: What We Can Learn from the History of Health Systems." Roger Larson Memorial Lecture, presented at the American Hospital Association annual convention, San Francisco, August 21, 1995.

The first formal prepaid “health care plan” may have been La Société Française de Bienfaisance Mutuelle in San Francisco. This cooperative was founded in 1849 by French immigrants to San Francisco who paid a nickel a member a month, hired physicians, and eventually built the French Hospital to provide care to their enrollees. If one looks at the origins of the Mayo Clinic, with its emphasis on salaried physicians, professional cooperation, and the public good through the Mayo foundation, one sees some of the same roots moving through that history.

The first example of a fully integrated system was in Oklahoma. A Syrian immigrant named Michael Shadid reacted to an experience he had with a colleague. A fee-for-service surgeon who needed money performed three unnecessary surgeries on three patients in one night and all three died. Michael Shadid was apparently so incensed that he began to search for an alternative way to organize care. He organized the first real cooperative of its sort in the United States as an integrated, prepaid health care system in Elk City, Oklahoma. The Cooperative Hospital of Elk City is now Great Plains Regional Medical Center; it converted from cooperative status in 1965.

Right after World War II, what we now know as Kaiser Permanente, Group Health Cooperative of Puget Sound, Health Partners, and others began to emerge as forces in American medicine. The Harvard Community Health Plan also later emerged.

Characteristics of Managed Health Care Systems

- ▶ ***Prepayment.*** You receive a lump sum at the beginning of a period of time and in response, you provide the care for the population. It’s now called capitation. It had its roots in the 1850s.
- ▶ ***Defined Population.*** You deal with an enrolled population. You know the patients or the population from which you’re going to draw your patient base, and for which you assume responsibility.
- ▶ ***Alignment of Incentives.*** There is an alignment of incentives among physicians and the health plan. The incentives are directed at taking care of that population in the most effective and efficient way possible.

- ▶ ***Physician Management of Clinical Care.*** In contrast to what is emerging in managed contracting, managed discounting, and insurance kinds of organizations, in these original integrated systems the physicians were responsible for clinical decision making, for determining how patients were going to be cared for individually and collectively. In many of them, physicians worked together with business people to set the policies and the directions for the organization itself. That stands in stark contrast to many of the managed care kinds of organizations currently, in which the insurance company or the health plan is involved in making clinical decisions by putting limits on benefits or on the way things are done. The worst manifestation of this is the “1-800-no you can’t” number.
- ▶ ***Clinical Integration.*** That is, trying to bring together in the most efficient way possible the elements of care in order to deal with an individual patient or a collection of patients.
- ▶ ***Not-for-Profit Status.*** Almost all were organized as public benefit organizations, corporations, that is 501(c)(3) or not-for-profit organizations, whose purpose was to serve the public. Profits were used to improve the system of care, the equipment, the facilities, the benefits, or returned to the members, by law, in the form of lower premiums.
- ▶ ***Voluntary Membership.*** Another key characteristic of most of these organizations that emerged after World War II was the importance of dual choice. That is, people should not be forced into an integrated health care system but rather should have a choice. That’s been a principle that’s driven this particular segment of the industry for almost 50 years.

The last thing that Emily Friedman observed, which is important as we look forward, is that in the competition between traditional fee-for-service medicine and prepaid integrated systems, the integrated systems have won. New forms of care management beyond the alternative fee-for-service independent doctor or freestanding hospital system are now being invented.

The Lessons and Future of Managed Care

About 70 percent of people in the United States now receive their care in some form of managed contracting, managed discounting, or managed care organization. A noted Wall Street analyst predicts that by the end of the decade there will be a very small residual of traditional fee-for-service medicine and that the rest of the country will be receiving its care through some form of managed care organization.

What are the lessons we can draw from the integrated care systems that have been in existence for 50 years or more?

Quality. Quality is where this question of the impact on health and health status comes to the fore. We have very limited tools by which to measure health care quality. We can look at training, board certification, JCHO accreditation, and more forms of structural quality. We can look at the processes by which care is assessed through quality assurance systems, which is what JCHO does, and now the National Committee on Quality Assurance (NCQA). But in general we don't have terrific ways to measure quality. Nonetheless, there is a reasonable collection of data that suggests that in the fully integrated care systems, like Harvard, Group Health Cooperative, and Kaiser Permanente, care is superior.

First of all, there are the external assessments in the 30 plus hospitals that we, the Group Health Cooperative, or Harvard own. Our hospitals tend to be very highly rated in the accreditation process, often with commendation. The recent NCQA reviews of managed care organizations have resulted in almost all fully integrated systems receiving the full accreditation and it's a fairly tough accreditation hurdle in its current form. Research by independent bodies also corroborates the notion that there is some link between the integrated prepaid practice systems of the sort that I've mentioned and quality. For example, in California, for the last decade a survey called the Williams Study has been done every two or three years; it looks at the outcomes for low birth weight babies, corrected by what we understand to be risk factors. Our hospitals have been in the top quartile of those studies in each of the last three surveys. In another independent study on cardiovascular surgery morbidity and mortality, our hospitals in San Francisco and Los Angeles always end up in the top quartile. Studies like these are beginning to provide evidence about the

relationship between integration of care, alignment of incentives, physician management, and quality.

Measuring Quality. Technology assessment suggests that somewhere in the range of 15 to 20 percent of health care that's practiced in the United States is based on sound population-based studies, that is, knowing what is going to work for what populations under which circumstances. The rest is based on outstanding biomolecular research, habit, and where you happen to have been trained. We have a long way to go to establish the basis, with sound population-based research, for understanding outcomes in health care. We also know that the health care that's practiced across the country is enormously variable. I think the numbers are at a 300 plus percent variation in the use of diagnostic and treatment aids from one community to another across the country, with no appreciable difference in the outcomes. We also know from recent studies by the Harvard School of Public Health, for example, in the hospitals of New York, about the problems of medical misadventures in hospitals. It's called "the silent epidemic." Our systems for quality control in the United States are very primitive. The measurement systems are getting better, but it's going to be some time before we have the kind of data that will allow us to determine what works for which populations under what circumstances across the spectrum of care that we're now providing.

Because of this lack of science and this variability the greatest opportunities for managing costs in health care come from improving quality. As the quality goes up, the costs go down. There is so much variation in practice patterns across the country and so little integration or organization of care to support appropriate care patterns that there is enormous waste in the system related to that alone. It isn't about fraud. It isn't about profit maximizing. It's that we are still not well grounded in our science.

I think another piece of evidence has to do with contributions to the medical care standards in the country. The current information that we operate on concerning colorectal cancer or breast cancer screening, proper immunization of children, or the care of women who had a prior Cesarean section and the possibility of having subsequent babies by normal vaginal delivery, and the major population-based science that has been established around these questions has come primarily from fully integrated health care systems like Group Health Cooperative, Harvard, and Kaiser Permanente.

Lourie Memorial Lecture Policy Brief

Work on the social HMO, which looks at ways to link together medical care with other social support systems under Medicare, has also been spearheaded in these kinds of organizations. The original work that looked at what would happen if we mainstreamed people who were covered under medically indigent programs like Medicaid also occurred in these kinds of programs, signifying significant contributions to the way in which we could provide care to the poor.

***Teaching Mission.* One of the top producers of primary care physicians in the country is Kaiser Permanente, and when it's coupled together with Group Health Cooperative of Puget Sound, and Harvard and Health Partners, we have a tremendous impact on training primary care physicians for the country.**

There is a link between these fully integrated, aligned systems and quality to the extent we can measure quality.

***Incentives.* We are learning from experience with managed discounters and managed care organizations that incentives matter in health care. As physicians, we are constrained by professional ethics. Because of the lack of clear-cut definition of what is appropriate care, the opportunities for us to make decisions at the margins, of either doing too much or too little, are substantial. We have continued to experiment with our kinds of systems, trying to find the right balance of incentives that reward physicians and other health professionals for taking care of enrolled populations—to pay them for winning.**

If one looks at the way the Mayo Clinic, the Cleveland Clinic, Virginia Mason, or Group Health Cooperative and Harvard Community Health Plan and other organizations like ours operate, one sees a focus on salaried physicians with bonuses that are dependent on how well the organization as a whole does, and how well the organization meets its social goals of improving health or improving satisfaction. That seems to be a very powerful way to organize the incentives for physicians.

***For-Profit versus Not-for-Profit Status.* The board's responsibility in a for-profit company is to maximize return for shareholders. Management is typically paid on the basis of how they have managed return for shareholders. In not-for-profit health care organizations, for example, in my situation, I don't get any more money for maximizing profit, for exceeding**

what we need to invest in the well-being of the institution. Any increase in my bonus comes from what happens to health status and satisfaction and member growth. That is the difference between the for-profit and not-for-profit incentives. There's a real question about what happens under pressure, when margins are squeezed and the incentives are to maximize shareholder return or to provide public benefit.

Integration of Care. I've discussed care integration under the rubric of quality. Now I want to focus specifically on the integration of care. When we think about traditional health care in the United States, we think about a very fragmented system with individual doctors or small group practices that take care of a certain segment of the illness or the patient. When one thinks about providing care that way, and lay that up against the complexity of the diseases that we face now in the late 20th century, especially the impact of chronic disease on our population, one begins to understand that that method of organization may not be up to the task. When you can array and align educational activities, home health activities, hospice activities, hospital care, nursing care, and physician care, and you can build the systems that meet the needs of those with serious illnesses, then you understand the power of integration to provide superior care.

Let me give you a simple example—the breast cancer screening program and early detection program of Group Health Cooperative of Puget Sound. Now normally when we think about breast cancer screening and early detection we think about having a good mammography program. That's just one adjunct, one modality for screening. When you have an enrolled population, you can segment the population by risk factors, and you can intercede with different elements of the population based on their risks. You can have an intensive program of education, self-breast exam, and mammography screening for women with a family history of breast cancer. You can have a very different kind of program for the women under 40 who have none of the risk factors. In addition to the education and screening program, you can also set up a program for quick diagnosis and intervention when suspicious lumps are found. In an integrated system, you can set up support and educational programs for patients who've just been discovered with cancer. You can set it up all the way down through the system for a population such that, as in Group Health Cooperative of Puget Sound, the find rates are very high, the staging is early in the course of disease, and the savings in human life are significant. That's the value of an integrated system.

Financing Health Care. Disease is fundamentally a random walk. Who it occurs in, when, and in what form is largely unpredictable. We've learned to assess risk factors so we can increase our understanding of the probability that disease may develop, but with some notable exceptions most disease occurs relatively randomly. It is a function of luck and your parents. Now what does that imply in terms of health insurance? What it suggests is that the way you would most effectively deal with a random event, that has enormous consequences in terms of cost, would be to spread the risks over large populations. The broader the population, the more the impacts of disease are dampened for the individual. We've learned over the last 40 or 50 years that the push for broader benefits came from our physicians. As we identified things that needed to be covered in order to take care of patients, our benefit packages expanded. It was not market driven, it was not employers or labor unions asking for the moon. It had to do with quality of care. What we've seen as we've tried to respond to the marketplace in the last few years is, as you reduce benefits you get real changes in the health-care seeking behavior of members. Relatively quickly you begin to get aberrant health-seeking patterns, such as putting off care. As a consequence, disease is intercepted later, not earlier. Prevention services, even secondary prevention services, often are foregone, and we end up with a more expensive kind of health care. It certainly is poorer quality when care is avoided in that form.

Consumer Expectations. The next observation has to do with consumer attitudes. American consumers have a love affair with new technologies—with all of the latest things that can keep us from getting older and dying.

A second element that involves consumers in the United States is that choice, whether real or illusory, is a critical aspect in driving public policy decisions of a wide array of stripes. It's particularly true in health care.

For 50 or 75 years we've been trained to think that more care is better care and that the higher tech the place is that you go for care, the better the quality. It's deeply rooted in the American psyche that more is better. Whereas, we at Kaiser Permanente believe that the best care is the care that works. It is a constant educational process to wean people away from their love affair with technology and talk instead about appropriate care. Unfortunately, the general belief is that when you're talking in those terms you're rationing

or withholding care. And it poses a real dilemma as we move into the managed care era in American medicine.

Issues for Further Study

The fundamental question that I think we need to address is, can the for-profit health plans advocate appropriately on behalf of their patients and members when faced with the margin squeeze and the need to meet the expectations of shareholders, who are the primary focus and responsibility of the boards of directors of those companies?

Most of health care and the health sector is for-profit. However, most hospitals in the United States are still not-for-profit. The use of hospitals is dropping. At least two studies suggest that half the hospital beds in the United States will be closed by the end of the decade. We're finding more ways of taking care of patients in ambulatory and non-hospital settings, as are many people across the country. The real issue with this for-profit/not-for-profit question is in the health plans, the managed care organizations. It is fascinating and distressing that in many parts of the United States, including the State of California, the conversion of not-for-profit to for-profit health plan enterprises has taken place with virtually no public debate. In contrast, in the 1980s a law was passed in Minnesota that basically forbade the creation of for-profit health plans. Efforts are now underway to overturn that law. The rapid growth in managed care is occurring in the for-profit sector, and it raises some very interesting questions for us in terms of public policy. Fundamentally, the dilemma is one in which we are pitting the investor-owner-shareholder health care juggernaut against history, evidence, and a generally underperforming and undercapitalized not-for-profit sector.

There is no historical precedent, that I'm aware of, in any sector of the economy in which there is a battle going on between not-for-profit and for-profit institutions. But if history is any guide, the juggernaut certainly has the upper hand.

The real question that will play itself out over the next five to seven years is, can those plans, those organizations that are focusing on managed contracting, convert to focusing on managed care?

I've used terms like managed contracting, managed discounting, and managed care to describe different kinds of approaches. Those are the choices in health care right now. *Managed contracting* is a form of financing, usually an insurance company or a so-called managed care organization that's been a conversion from, typically, an insurance base. Many of the Blues conversions have done this—accreting lives and members, then contracting with outside providers for the care. The game is to get leverage, either the financing system on the providers, or in contrast, as the providers try to organize, the providers on the financing system. That's a contracting game—trying to obtain cost containment through contracting concessions.

Managed discounting is fundamentally the same idea. I've got enough members to have leverage over you. I'll pay your marginal costs in Hospital X, Y, or Z, or I'll pay you, Physician X, Y, or Z, a capitation rate of this. Take it or leave it! If you leave it, I'm walking away with a good number of your patients, who now are in my plan. That's a strategy that will work as long as there's a significant imbalance in the supply and demand.

The real opportunities for improving impacts in health care and cost performance lie in improving quality. To do that requires that care is integrated and that we know what can have the most significant impact on the health of enrolled populations. To do this will require large investments in information systems; major efforts to develop protocols and guidelines for physicians; massive physician incentives; and ownership incentives. This will be a very fundamental battle in health care, as we watch to see whether or not that conversion takes place.

The third major dilemma that we face is the insurance question. The more risk is spread, the more equitable it is because of the random nature of illness. Comprehensive benefits, properly designed, are the way to deal with the issue of quality and impact. Yet look at what's happening in the industry. The industry is taking a number of steps to fragment risk pools in order to avoid risk. Benefit structures are condensing. Employers are moving to far more flexibility in benefit design—reducing benefits, increasing co-pays, increasing deductibles, and cutting back on unnecessary benefits, from their point of view. At the same time that we have a body of evidence suggesting that comprehensive care and comprehensive social insurance may work to the advantage of a population, we're seeing

forces in the marketplace that are moving in the other direction. For many who are in the marketplace, products and the insurance game is the way in which they are competing.

Interestingly, when we look at what is happening in Washington, we see some of the same thinking. The medical savings account is being driven by a fundamental belief in offering choice to people. It means that the wealthy and healthy are going to have access to catastrophic health insurance in a savings account. The ill will then have to continue getting their care through regular insurance. Guess what that does to the price of regular insurance? Guess where the people who have chosen the medical savings account go when they get ill? They convert. It seems somewhat misguided.

A major conundrum for our country is that as risk pools are fragmented, benefit packages reduced, and employers become more draconian in the way in which they offer insurance to their employees, we continue to see a rise in the uninsured and the underinsured. People get care. It is where they get care, and at what cost, that is the problem. It's a penny wise-pound foolish kind of shortsightedness with which we have yet to come to grips.

The next major issue for us to consider comes out of our understanding of consumer attitudes. There is a significant anti-managed care bias reaction underway now. It began in 1994 and is accelerating at the national level. We have seen it in more aggressive ways in several states, beginning in 1992 and 1993. Consumers who believe more is better are frightened to death about managed care. Consumer advocacy organizations have been working overtime to try to create consumer awareness and protection around managed care. Physicians and hospitals that are trained in, and acculturated to, the traditional models of fee-for-service medicine are seeing the end of that particular way of doing practice. Their organizations, in many instances, are putting up a very strong fight against this shift to managed care. The American Medical Association has introduced the Patient Protection Act, which many of us believe is a Physician Protection Act, that seeks to preserve the status quo in medicine. Joined with consumer fears, it is fanning the anti-managed care flames.

There are also some pretty bad managed care organizations that create their own horror stories and their own self-fulfilling prophecy. In spite of the fact that over 70 percent of the population is now in some form of managed care, there is great uneasiness about this. It remains unclear as to when, if at all, that uneasiness will dissipate. Will we be able to deal

with creating an appropriate framework within which the managed care organizations should operate? This must define acceptable practices and protect consumers from the worst abuses of those systems in terms of incentives to withhold, avoid, or ration care.

What are we going to leave to our children? Research dollars are certainly being constrained. There is an open question as to whether or not the biomedical industry will continue to flood research with substantial dollars to offset the loss of federal funds. It is both at the biomolecular level, as well as at the population-based science development level, that we need continued evolution of our science and health care to push the frontiers in disease management. But we are in a very telling time. What will the managed care organizations' contribution be to research? What is the incentive to make investments in research and development and to share those findings in the public domain, rather than keeping them as a quasi-patent for shareholder gain?

Another question involves teaching. The academic health care institutions are in deep trouble around the country. There are serious questions about the teaching mission. Most academic hospitals are struggling to keep their heads above water—and few are succeeding. Who's going to do the teaching? What kinds of professionals need to be taught and where are they going to be taught? Again, if we have a managed care delivery system, what is the commitment, what is the responsibility of those managed care organizations to continue the teaching mission so essential to providing well-trained professionals for the generations that follow us?

Conclusion

Let me summarize. I've tried to provide a point of view from the trenches about what we've learned from 140 years of history with integrated systems, what we've learned about how to have an impact on health and health status in a way that's affordable and socially responsible. I've tried to draw from those experiences and those lessons some insight into the dilemmas we face, given that market forces are changing the health care system in ways that go far beyond anything we've contemplated through public policy intervention. I've proposed that the measure of our success in health care is our ability to improve the health of our citizens, in a way we can afford. I think the history of the fully integrated prepaid system demonstrates an unswerving focus on doing just that.

David M. Lawrence

There are critical lessons to be drawn from that history about quality care and system integration, about incentives, insurance, consumer attitudes, and so forth, which will be at the focal point of our public debate as we look to the marketplace driving us forward over the next decade. I've suggested in passing that we have really just seen the tip of the iceberg in terms of the transformation in the market forces affecting health care. My belief is that, contrary to popular opinion, over the next 5 to 7 years the continued push will actually drive prices down in health care, in most competitive markets, given the excess supply that exists and the opportunities for performance improvement. We anticipate that even as the population is converting to a managed care kind of delivery system, there will be enormous pressures to continue to ratchet costs down. This raises troubling questions about what the consumer will be getting under those circumstances. I am just as worried about what happens if you continue an unfettered fee-for-service system that historically has provided too much care. So I don't mean to say that what we've been doing historically has been right. But this new system that we're moving into carries its own dangers.

Finally, I believe that the experience of organizations like Harvard Community Health Plan, our own organization, and the others around the country that are organized according to the principles I have outlined can shed important light on these dilemmas, and, going forward, can serve as a very critical benchmark about how we can do things in a way that impacts on the health of the populations in the most affordable way possible.